Please fax both pages of completed form to your PAH team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Pirfenidone

accredo®

677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Sex at birth: ☐ Male ☐ Female Preferred pronouns _____ Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Dose	Directions	Quantity/Refills
☐ pirfenidone	Initial titration: ☐ 267mg tablets ☐ 267mg capsules	Initial titration: ☐ Days 1-7: 1 tablet by mouth 3 times/day with meals Days 8-14: 2 tablets by mouth 3 times/day with meals Days 15+: 3 tablets by mouth 3 times/day with meals ☐ Days 1-7: 1 capsule by mouth 3 times/day with meals Days 8-14: 2 capsules by mouth 3 times/day with meals Days 15+: 3 capsules by mouth 3 times/day with meals	☐ 1-month supply No refills
	Maintenance dose: ☐ 267mg tablets ☐ 267mg capsules	Maintenance dose: ☐ 3 tablets by mouth 3 times/day with meals ☐ 3 capsules by mouth 3 times/day with meals	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
	Maintenance dose: ☐ 801mg tablets	Maintenance dose: ☐ 1 tablet by mouth 3 times/day with meals ☐ Other _____	
☐ Other _____			☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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